

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047832

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 139

Primary Registration District No. 5535

Registrar's No. 92

FILED DEC 30 1963

VS 300 Rev. 4/59	DATE AMENDED	1. PLACE OF DEATH a. COUNTY <b>HOLT</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>HOLT</b>	
0440	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HICKORY TWP</b>	Length of stay in 1b <b>35 yrs.</b>	c. CITY OR TOWN <b>OREGON</b>
20440		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7 mi N.E. of OREGON</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7 miles Northeast</b>
3		3. NAME OF DECEASED (Type or print) <b>WILLIAM HIRAM SMITH</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1963</b>
4 0		5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
5 1	INSTEAD OF	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and state or country) <b>ANDREW Co., Mo.</b>
6		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>E W. Smith</b>
7 0		13b. MOTHER'S MAIDEN NAME <b>FRANCES PRAISEWATER</b>		14. NAME OF HUSBAND OR WIFE <b>CLEO Smith</b>
8 2		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of serv) <b>No</b>		17. INFORMANT <b>MRS. William H. Smith, OREGON, Mo.</b>
9 4/12 X	DOCUMENT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR-renal disease.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>
10		Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)
11		DUE TO (c)		
12 90-2		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PROSTATE OPERATION 1 Mo. ago.</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
13 10	MEDICAL CERTIFICATION	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
		20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
		21. I attended the deceased from <b>No</b> to <b>No</b> and last saw her him alive on <b>No</b> Death occurred at <b>8:30</b> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		
	BY AFFIDAVIT OF	22a. SIGNATURE (Degree or title) <b>James H. Crawford D.O., coroner Holt Co.</b>	22b. ADDRESS <b>Oregon Mo.</b>	22c. DATE SIGNED <b>12-26-63</b>
		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-26-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT HOPE CEM.</b>
		23d. LOCATION (City, town, or county) <b>MOUND City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-26-1963</b>	26. REGISTRAR'S SIGNATURE <b>James H. Crawford</b>
		24. FUNERAL DIRECTOR <b>JAMES H. CRAWFORD MOUND City, Mo.</b>		

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James H. Crawford  
Licensed Embalmer No. 4796

P. O. Address Monroe City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.